Alchemy Healing Arts Center, LLC

NEW CLIENT INFORMATION

Therapist_____

Name _____Date_____

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____ Birth Date _____

Family – Spouse/Partner, Kids, Creatures?_____

Email Address _____ May we add you to our mailing list? _____

Best Phone to Contact _____C-W-H? Alternative Contact # _____

Emergency Contact – Name_____ Phone#_____

How did you learn about us? _____ May we thank them for their referral?_____

Have you received Professional Massage Therapy or Bodywork before? _____

What Kinds? _____ How often? _____

Please check off any of the following conditions or symptoms which apply to you now or in the past:

____ High Blood Pressure	____ Osteoporosis	____ Pelvic injury
____ Contact Lens	____ Skin Infections	____ Hearing difficulties
____ Low Back Pain	____ Hypo or Hyperglycemia	____ Seizures
____ Allergy to Nut Oils	____ Contagious Conditions	____ Depression
____ Other Allergies	____ Muscle Sprain / Strain	____ Constipation/Irregularity
____ Diabetes	____ Heart Attack / Stroke	____ Hormonal Changes
____ Pregnant	____ Arthritis	____ Cancer
____ Blood Clots	____ Headaches or Migraines	____ Lymph Nodes Removed
____ Low Blood Pressure	____ TMJ Disorder	____ Radiation Therapy
____ Varicose Veins	____ Head injury	____ Lymphedema

Details for Above:_____

_____

Please list and explain other conditions/symptoms you are or have experienced: _____

Have you had any serious or chronic illness, surgeries, or traumatic accidents? _____

If yes, please give dates and details:_____

_____

Pre-Natal Only: Due date_____ Current trimester _____

Are you currently, or have you at any time within the last 12 months been under the care of a physician? If so, for what condition?_____

Are you on any medication? ___ If yes, which ones, and what condition are they prescribed for? _____

_____

If appropriate, and with your knowledge, may we have permission to contact your Doctor / Therapist? _____

Doctor / Therapist Name: _____Telephone _____

What forms of movement or activity do you enjoy regularly and how often?

_____

Do you drink caffeinated beverages? _____ Do you consume alcohol? _____

Do you smoke cigarettes? _____ How much water do you drink daily? _____

What are you passionate about? _____

What else would you like us to know about you to best provide for you during your session? _____

_____

What goals do you have for this and continuing sessions?_____

I have completed this health form to the best of my knowledge. I understand that Massage Therapy, CranioSacral Therapy®, Lymph Drainage Therapy® and other forms of hands on bodywork services are a therapeutic health aid. They do not take the place of a physician's care when indicated. Any information exchanged during a session is confidential and is only used to provide you with the best health care services.

If I am not able to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have a true emergency. In this case, I will call ASAP to reschedule my appointment. I understand that if I miss a scheduled appointment without giving 24 hour notice, I agree to pay the full appointment fee.

Signature _____ Date _____

If a minor, signature of Parent/Guardian is required:

Signature _____ Date _____